Outcome and ASsessment Information Set

Workbook To Accompany HOME HEALTH AGENCY ASSESSMENT STRATEGIES VIDEO

2000

Department of Health and Human Services
Health Care Financing Administration

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PREFACE

The Health Care Financing and Administration (HCFA) has developed a training video with an accompanying workbook demonstrating patient assessment strategies for home health clinicians to utilize in providing care. The purpose of the video is to illustrate how clinicians acquire patient information using a variety of assessment techniques. Two vignettes depicting segments of typical home health care visits are included in the video. Demonstrated are approaches that clinicians can utilize to gather information for certain items in the Outcome and ASsessment Information Set (OASIS). The first vignette focuses on ADL and IADL activities, while the second depicts aspects of the mental status assessment.

The workbook and video are complementary. The first section of the workbook provides an overview of assessment techniques and reviews brief instructional points necessary for effective use of the vignettes. Each vignette is then presented separately. A copy of the OASIS items to be used with each vignette is included. You are encouraged not to look at the correct responses prior to viewing the video, but rather to answer the OASIS items using only the information available as portrayed in each vignette. The appropriate (i.e., correct) responses for the OASIS items, with accompanying rationale, are provided for each situation. Suggestions for additional assessment strategies and other potential OASIS items that could be addressed based on the information presented in the scene are also included. In the Appendix are copies of the "Item-by-Item Tips" from Chapter 8 of the *OASIS Implementation Manual.*

Home health agencies are encouraged to make copies of the workbook for staff to utilize as they view the video. The workbook and video can be used as an effective individual or group activity. Clinicians can discuss the vignettes in practical working sessions to increase their expertise in the comprehensive patient assessment, based on the skills of observation, interview, and measurement techniques.

PATIENT ASSESSMENT (OVERVIEW)

A brief overview of patient assessment in home health care is presented here. For additional information, you are directed to the *OASIS Implementation Manual*, where Chapter 4 focuses exclusively on the comprehensive assessment and OASIS. An attachment at the end of that chapter provides supplemental references on patient assessment.

- A *comprehensive* assessment involves collecting data on multiple aspects of the patient and the environment. The OASIS data set is not a complete assessment in itself but must be integrated into the agency's comprehensive assessment for each time point.

- Patient assessment data are collected through a combination of methods -- including interaction with patient/family, observation, and measurement. Using only one approach limits both the amount and quality of the information obtained. Direct observation is the preferred method for data collection, but some data may be obtained only by interview. This interaction should supplement, not replace, observational techniques.

- From a clinical perspective, a typical comprehensive assessment includes:

  - An investigation of the patient's chief complaint (or chief problem);

  - A review of pertinent past health history, including all current medications;

  - A review of supportive assistance currently available to the patient;

  - An examination of the patient's physical, functional, and psychosocial status; and

  - An evaluation of the patient's environment.

- The sequence of the assessment often varies depending on the skill level of the clinician and the specific patient situation. Generally, the more skilled the clinician, the greater degree of flexibility in conducting the assessment -- in contrast to the novice clinician who is confident only in conducting a highly structured assessment.

  - Example: The clinician arrives at the patient's home in the midst of a "crisis." The critical situation must be addressed before an assessment can be effectively conducted. While addressing the "crisis," the skilled clinician is collecting a broad array of assessment data.

  - Clinicians must use creativity and flexibility to obtain patient assessment data pertinent for care planning.

- The *OASIS Implementation Manual* includes a suggested "mapping" of OASIS items into the major components of a patient assessment (see Table 8.1 in Chapter 8).

- The patient is the preferred source for data necessary to collect by interview and interaction, although family members/caregivers (or other health care providers) can provide the information when the patient is unable to do so.

- When the assessment is complete, the clinician reviews the data for gaps or inconsistencies and begins the initial care planning process.

  - The clinician involves the patient/caregiver/family in the planning process that includes establishing realistic goals for care.

  - Plans are discussed and confirmed with the physician.

  - The clinician informs other disciplines of the situation and the need for their involvement and includes them in the planning process.

  - The clinician explains next steps and details of the plan to patient/care-giver/family.

- Skilled clinicians assess the patient in all interactions, not merely at designated assessment points, allowing her/him to continuously evaluate, modify, and update the plan of care and to facilitate the patient's achievement of desired goals.

HOW TO VIEW THE VIDEO AND USE THIS WORKBOOK

The video presents two short vignettes that depict portions of a typical home health comprehensive assessment visit. The first scenario focuses on assessment of certain ADL and IADL items, while the second depicts aspects of the mental status assessment. As you view the video, remember that you enter each assessment "in progress." Some visit activities have already occurred (off camera) and other important aspects are likely to follow the scenes depicted. Each vignette has an accompanying workbook section, which includes:

- A brief description of the patient situation presented in the vignette;
- The set of specific OASIS items to assess while viewing the video;
- Correct response pages that include the rationale for each response; and
- Additional OASIS items that could be assessed (or partially assessed) from the vignette.

Keep in mind the key aspects of assessment -- interaction with patient and family, observation, and measurement -- as you view the vignettes. At the end of each vignette, you will be instructed to turn off the video and respond to the indicated OASIS items. (You should not view the correct responses until you make your own decisions for the items.) Carefully review the completed response items and accompanying rationale. Then proceed to the second vignette, reading its introductory description. Turn the video back on and view the assessment. At the end, complete the second set of OASIS items. Again review the appropriate response for the OASIS items and accompanying rationale. If you have additional questions on specific items, refer to Appendix A of this workbook, which includes the appropriate Item-by-Item Tips from the *OASIS Implementation Manual.*

Each workbook section includes additional OASIS items that might be fully or partially assessed while viewing the vignette. Consider what additional information (data) you would need to fully complete the patient assessment for these items.

The video and workbook can be effectively used with groups of agency clinical staff for training (or retraining) purposes. Group discussion about the vignettes and items might follow the viewing of each patient situation. Do all staff members agree on the responses? Why or why not? What assessment techniques would staff suggest to obtain more complete information? The listing of additional items that might be assessed from the scenario can facilitate discussion about important items that should be included in assessments, as well as approaches to achieve an accurate comprehensive assessment. The points presented in the overview to patient assessment in this manual or in Chapter 4 of the *OASIS Implementation Manual* can be reinforced. Staff could discuss strategies to review the quality of assessments currently being done at the agency and to develop plans for further approaches to improve overall competence in patient assessment.

VIGNETTE 1: Thomas Domino

Characters: *MR. THOMAS DOMINO (Patient); PHYLLIS (His Daughter); ELLA FITZSIMMONS (Nurse)*

Visit: *Start of Care assessment, about 11:30 AM.*

Patient's Condition: *Mr. Domino is 83 and is living with his 48-year-old daughter, Phyllis. He had a stroke three weeks ago, was hospitalized for four days, and then spent the remaining time until yesterday in a Skilled Nursing Facility (SNF) where he received physical therapy, occupational therapy, and speech therapy daily.*

We are viewing an assessment at a point when the nurse has already learned a number of things about this patient. He has some problems with short-term memory and is able to walk alone only with the use of a quad cane. The memory deficit causes him to appear confused at times, but he does know his name and that he's at his daughter's home, where he has not lived before. Phyllis intends to be with him 24 hours a day and will have her daughter or son stay when she needs to run errands.

At our entry into the assessment, Mr. Domino is seated at the kitchen table, eating lunch. The nurse has assessed his gastrointestinal status and has learned that he's been following a low salt diet for a few years and that his daughter did his food shopping for him prior to the stroke. His appetite has been and is reported to be good, though he had speech therapy in the nursing home for difficulties with chewing and swallowing.

Viewing Goal: *To assess M0690 (Transferring), M0700 (Ambulation/Locomotion), M0710 (Feeding or Eating), and M0720 (Planning and Preparing Light Meals).*

Review the OASIS items, then view the vignette.

Client Name: _____ **Clinical Record No.:** _____

VIGNETTE 1

ADL/IADLs

For M0690-M0720, complete the "Current" column for all patients. For these same items, complete the "Prior" column only at start of care and at resumption of care; mark the level that corresponds to the patient's condition 14 days prior to start of care date (M0030) or resumption of care date (M0032). In all cases, record what the patient is *able to do*.

(M0690) Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

Prior	Current		
☐	☐	0	- Able to independently transfer.
☐	☐	1	- Transfers with minimal human assistance or with use of an assistive device.
☐	☐	2	- Unable to transfer self but is able to bear weight and pivot during the transfer process.
☐	☐	3	- Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
☐	☐	4	- Bedfast, unable to transfer but is able to turn and position self in bed.
☐	☐	5	- Bedfast, unable to transfer and is unable to turn and position self.
☐		UK	- Unknown

(M0700) Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Prior	Current		
☐	☐	0	- Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
☐	☐	1	- Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
☐	☐	2	- Able to walk only with the supervision or assistance of another person at all times.
☐	☐	3	- Chairfast, unable to ambulate but is able to wheel self independently.
☐	☐	4	- Chairfast, unable to ambulate and is unable to wheel self.
☐	☐	5	- Bedfast, unable to ambulate or be up in a chair.
☐		UK	- Unknown

(M0710) Feeding or Eating: Ability to feed self meals and snacks. **Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.**

Prior	Current		
☐	☐	0	- Able to independently feed self.
☐	☐	1	- Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet.
☐	☐	2	- Unable to feed self and must be assisted or supervised throughout the meal/snack.
☐	☐	3	- Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
☐	☐	4	- Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
☐	☐	5	- Unable to take in nutrients orally or by tube feeding.
☐		UK	- Unknown

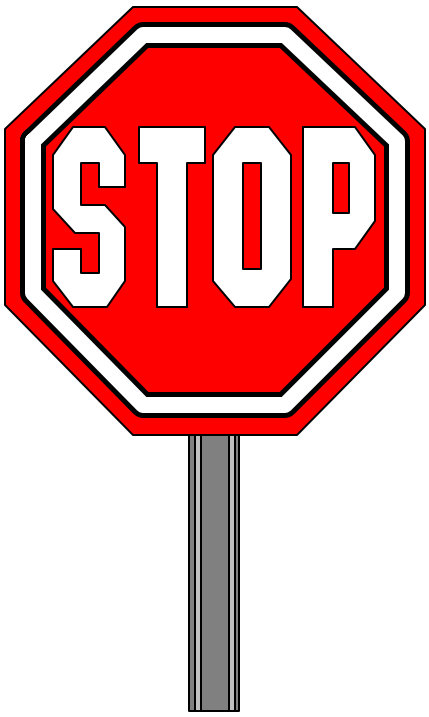
Client Name: _____ **Clinical Record No.:** _____

VIGNETTE 1 (Cont'd)

(M0720) Planning and Preparing Light Meals (e.g., cereal, sandwich) or reheat delivered meals:

Prior	Current			
☐	☐	0	-	(a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
☐	☐	1	-	Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
☐	☐	2	-	Unable to prepare any light meals or reheat any delivered meals.
☐		UK	-	Unknown

COMMENTS: _____



No Peeking

Answers and Rationale follow

View Vignette 1 and complete the sample OASIS assessment items before proceeding with workbook.

Summary: From this part of the assessment, the nurse can record the following responses:

HCFA AT HOME
Health Care Financing Administration

START OF CARE ASSESSMENT
(Also used for Resumption of Care Following Inpatient Stay)
OASIS-B1 SOC (8/2000)

Client Name: _____ **Clinical Record No.:** _____

VIGNETTE 1

ADL/IADLs

For M0690-M0720, complete the "Current" column for all patients. For these same items, complete the "Prior" column only at start of care and at resumption of care; mark the level that corresponds to the patient's condition 14 days prior to start of care date (M0030) or resumption of care date (M0032). In all cases, record what the patient is *able to do*.

(M0690) Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

Prior	Current			
☐	☐	0	-	Able to independently transfer.
■	☐*	1	-	Transfers with minimal human assistance or with use of an assistive device.
☐	☐	2	-	Unable to transfer self but is able to bear weight and pivot during the transfer process.
☐	☐	3	-	Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
☐	☐	4	-	Bedfast, unable to transfer but is able to turn and position self in bed.
☐	☐	5	-	Bedfast, unable to transfer and is unable to turn and position self.
☐		UK	-	Unknown

M0690 Prior: Daughter describes patient as able to get up out of bed using cane in the hospital at the point of going to the nursing home. Patient also describes use of cane to transfer in the nursing home, so Response 1 is marked.

M0690 Current: Patient states he is able to transfer on and off toilet with only his cane (Response 1), but observation of sit-to-stand transfer indicates more than minimal human assistance needed. M0690 assesses the patient's ability to transfer in three settings. The nurse has the report of the toilet transfer ability and must observe transferring ability in other situations (bed to chair, into and out of tub or shower) to determine his current transferring ability. To complete this item accurately, more information is needed, e.g., the clinician should observe the patient in the other two settings.

* Additional assessment information is needed. See accompanying rationale in the box above.

Client Name: _____ **Clinical Record No.:** _____

VIGNETTE 1 (Cont'd)

(M0700) Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Prior	Current			
☐	☐	0	-	Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
☐	■	1	-	Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
■	☐	2	-	Able to walk only with the supervision or assistance of another person at all times.
☐	☐	3	-	Chairfast, unable to ambulate but is able to wheel self independently.
☐	☐	4	-	Chairfast, unable to ambulate and is unable to wheel self.
☐	☐	5	-	Bedfast, unable to ambulate or be up in a chair.
☐		UK	-	Unknown

M0700 Prior: Patient describes use of gait belt and human assistance for ambulation/locomotion two weeks ago, so Response 2 is marked.

M0700 Current: Patient demonstrates ambulation ability using cane to walk alone (Response 1). While Mr. Domino's ambulation ability is not well demonstrated (only three steps) both he and his daughter say he walked in the hall with a cane in the nursing home.

(M0710) Feeding or Eating: Ability to feed self meals and snacks. **Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.**

Prior	Current			
☐	☐	0	-	Able to independently feed self.
☐	■	1	-	Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet.
■	☐	2	-	Unable to feed self and must be assisted or supervised throughout the meal/snack.
☐	☐	3	-	Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
☐	☐	4	-	Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
☐	☐	5	-	Unable to take in nutrients orally or by tube feeding.
☐		UK	-	Unknown

M0710 Prior: Daughter describes patient as being totally fed by staff 14 days ago, but denies any supplemental tube feedings. Therefore, Response 2 is marked.

M0710 Current: Patient noted as able to feed self but food must be cut up and liquids thickened. Response 1 is noted.

Client Name: _____ **Clinical Record No.:** _____

VIGNETTE 1 (Cont'd)

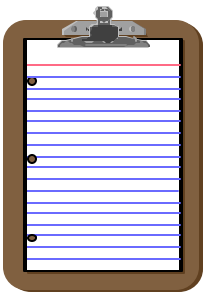
(M0720) Planning and Preparing Light Meals (e.g., cereal, sandwich) or reheat delivered meals:

Prior	Current			
☐	☐	0	-	(a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
☐	☐	1	-	Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
■	■	2	-	Unable to prepare any light meals or reheat any delivered meals.
☐		UK	-	Unknown

M0720 Prior: Daughter notes that patient unable to do any meal preparation activities when first transferred to nursing home. OT only began to work with patient on meal preparation during the last four days of nursing home stay. Response 2 is marked.

M0720 Current: Patient reports not being able to fix a small meal now or reheat a prepared meal. This is also noted as Response 2.

COMMENTS: _____



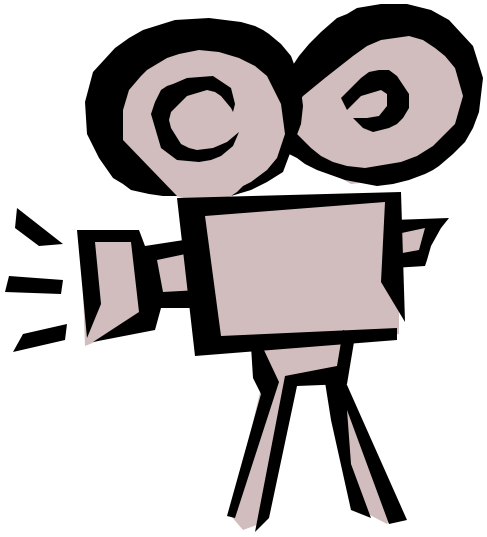
ADDITIONAL OASIS ITEMS TO ASSESS DURING VIGNETTE 1

In addition to the noted items for which data could be collected during the vignette, the clinician can begin assessing other items as well. During a home health visit, a clinician gathers information that subsequently is analyzed and organized to answer other OASIS items (e.g., M0270 - Rehabilitative Prognosis). While viewing the scenario featuring Mr. Domino's situation, you could begin to evaluate several other OASIS items:

M0175 - Inpatient Facilities
M0200 - Medical or Treatment Regimen Change Within Past 14 Days
M0260 - Overall Prognosis
M0270 - Rehabilitative Prognosis
M0300 - Current Residence
M0340 - Patient Lives With
M0350 - Assisting Person(s) Other than Home Care Agency Staff
M0360 - Primary Caregiver
M0370 - How Often does the patient receive assistance from the primary caregiver
M0400 - Hearing and Ability to Understand Spoken Language
M0410 - Speech and Oral (Verbal) Expression of Language
M0560 - Cognitive Functioning

Are there other items for which partial data are available?

Please read
the background information and the
set of OASIS items for Vignette 2,
then return to the video
and view the
second vignette.



VIGNETTE 2: Martha Bean

Characters: *MRS. MARTHA BEAN (Patient); JUDY ROGERS (Nurse)*

Visit: *Start of Care assessment, about 10 AM.*

Patient's Condition: *Mrs. Bean is 84 years old and was discharged yesterday from a rehabilitation facility where she had been for ten days of therapy after being hospitalized for six days following hip replacement surgery (done because of a degenerative hip joint). She has a history of congestive heart failure, anxiety, and osteoarthritis. The agency had seen her for several weeks about a year ago after she was hospitalized for congestive heart failure. Her medications include Digoxin, Coumadin, Lasix, Potassium Chloride, and Extra-Strength Tylenol for pain.*

Patient's home is a small, one-bedroom apartment in a building for senior citizens only. Her rent is subsidized by the government, which enables Mrs. Bean to afford this apartment on her meager pension and small Social Security check. When we enter the assessment, we see Mrs. Bean on the sofa, where she sits most of the day. A multi-colored crocheted afghan lays across the back of the sofa. Her walker sits next to the sofa.

Viewing Goal: *To assess aspects of the patient's mental status, specifically M0560 (Cognitive Functioning), M0570 (When Confused), M0580 (When Anxious), M0590 (Depressive Feelings Reported or Observed), M0600 (Patient Behaviors Reported or Observed), M0610 (Behaviors Demonstrated at Least Once a Week), and M0620 (Frequency of Behavior Problems).*

Review the OASIS items, then view the vignette.

Client Name: _____ **Clinical Record No.:** _____

VIGNETTE 2

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M0560) Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)

- ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- ☐ 1 - Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

(M0570) When Confused (Reported or Observed):

- ☐ 0 - Never
- ☐ 1 - In new or complex situations only
- ☐ 2 - On awakening or at night only
- ☐ 3 - During the day and evening, but not constantly
- ☐ 4 - Constantly
- ☐ NA - Patient nonresponsive

(M0580) When Anxious (Reported or Observed):

- ☐ 0 - None of the time
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time
- ☐ NA - Patient nonresponsive

(M0590) Depressive Feelings Reported or Observed in Patient: (Mark all that apply.)

- ☐ 1 - Depressed mood (e.g., feeling sad, tearful)
- ☐ 2 - Sense of failure or self reproach
- ☐ 3 - Hopelessness
- ☐ 4 - Recurrent thoughts of death
- ☐ 5 - Thoughts of suicide
- ☐ 6 - None of the above feelings observed or reported

(M0600) Patient Behaviors (Reported or Observed): (Mark all that apply.)

- ☐ 1 - Indecisiveness, lack of concentration
- ☐ 2 - Diminished interest in most activities
- ☐ 3 - Sleep disturbances
- ☐ 4 - Recent change in appetite or weight
- ☐ 5 - Agitation
- ☐ 6 - A suicide attempt
- ☐ 7 - None of the above behaviors observed or reported

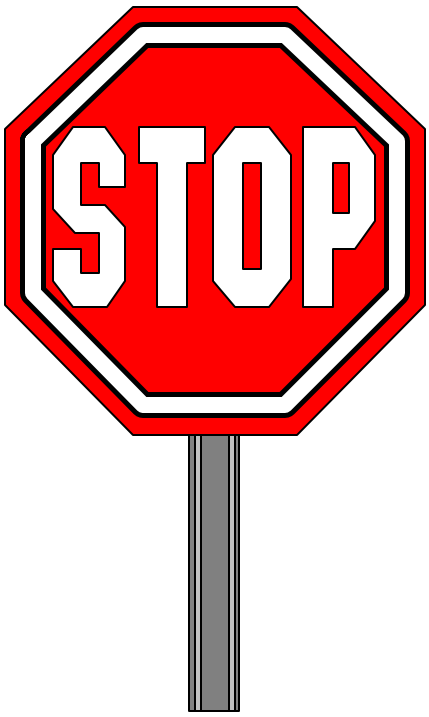
(M0610) Behaviors Demonstrated <u>at Least Once a Week</u> (Reported or Observed): (Mark all that apply.)

- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

(M0620) Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):

- ☐ 0 - Never
- ☐ 1 - Less than once a month
- ☐ 2 - Once a month
- ☐ 3 - Several times each month
- ☐ 4 - Several times a week
- ☐ 5 - At least daily

COMMENTS: _____



No Peeking

Answers and Rationale follow

View Vignette 2 and complete the sample OASIS assessment items before proceeding with workbook.

Summary: From the preceding interactions the nurse can make the following responses to OASIS items:

HCFA Health Care Financing Administration **AT HOME**

START OF CARE ASSESSMENT
(Also used for Resumption of Care Following Inpatient Stay)
OASIS-B1 SOC (8/2000)

Client Name: _____ **Clinical Record No.:** _____

VIGNETTE 2

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M0560) Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)

- ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- ■ 1 - Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

M0560: This patient is able to follow the conversation and to focus and shift her attention. She does acknowledge, however, that her memory is "not so good" but that writing things down (i.e., reminders) assists her cognitive functioning.

(M0570) When Confused (Reported or Observed):

- ■ 0 - Never
- ☐ 1 - In new or complex situations only
- ☐ 2 - On awakening or at night only
- ☐ 3 - During the day and evening, but not constantly
- ☐ 4 - Constantly
- ☐ NA - Patient nonresponsive

M0570: The patient denies confusion twice, including the presence of confusion at night. No other evidence of confusion is present.

(M0580)When Anxious (Reported or Observed):

- ☐ 0 - None of the time
- ☐ 1 - Less often than daily
- ■ 2 - Daily, but not constantly
- ☐ 3 - All of the time
- ☐ NA - Patient nonresponsive

M0580: The patient has a history of anxiety and describes several symptoms, including waking at night feeling like everything's "closing in on me" and feeling panicky in the daytime. These symptoms are described as occurring every night, but not continuously every day (only when she gets "worked up"). Therefore, Response 2 is selected as most appropriate. Note that the nurse addresses other possible causes for the night waking (e.g., pain, bladder fullness) in the assessment.

Client Name: _____ **Clinical Record No.:** _____

VIGNETTE 2 (Cont'd)

(M0590) Depressive Feelings Reported or Observed in Patient: (Mark all that apply.)

- ■ 1 - Depressed mood (e.g., feeling sad, tearful)
- ■ 2 - Sense of failure or self reproach
- ☐ 3 - Hopelessness
- ☐ 4 - Recurrent thoughts of death
- ☐ 5 - Thoughts of suicide
- ☐ 6 - None of the above feelings observed or reported

M0590: Several depressive feelings are reported by the patient. She notes that "sometimes I just sit here and cry and feel sorry for myself," that "I'm not doing anyone any good," and "I'm no good for me either." She also describes herself as "no good" for anyone since she is not able to take care of herself, though that is what her family expects. These statements and the observation of tearfulness lead to the marking of Responses 1 and 2 and not marking Response 6 (none of the above feelings observed or reported). Response 3 is not selected, as her feelings can be characterized as helpless, but not hopeless. In response to direct questions, the patient denies dwelling on death and thinking of suicide, so Responses 4 and 5 are not marked.

(M0600) Patient Behaviors (Reported or Observed): (Mark all that apply.)

- ■ 1 - Indecisiveness, lack of concentration
- ■ 2 - Diminished interest in most activities
- ■ 3 - Sleep disturbances
- ■ 4 - Recent change in appetite or weight
- ☐ 5 - Agitation
- ☐ 6 - A suicide attempt
- ☐ 7 - None of the above behaviors observed or reported

M0600: The patient reports not being able to concentrate enough to get through a book and having trouble staying interested in TV stories or in crocheting. She also reports sleep disturbances, which are verified by the nurse as not due to pain or urinary elimination problems. She also notes that her appetite has not been good since her surgery and that her weight may be a "little down." These statements and the observation of tearfulness lead to the marking of Responses 1, 2, 3, and 4 and not marking Response 7. *The patient is agitated at intervals during the video but not over 50% of the time, so Response 5 is not marked.* (If we were to see the entire assessment, we might reevaluate this response.) Suicidal thoughts are not present, so Response 6 is not marked.

Client Name: _____ **Clinical Record No.:** _____

VIGNETTE 2 (Cont'd)

(M0610) Behaviors Demonstrated <u>at Least Once a Week</u> (Reported or Observed): (Mark all that apply.)

- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ■ 7 - None of the above behaviors demonstrated

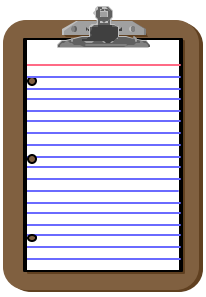
M0610: During the assessment, none of these behaviors is demonstrated, so Response 7 is marked. Her need for memory reminders is not of sufficient severity to mark Response 1.

(M0620) Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):

- ■ 0 - Never
- ☐ 1 - Less than once a month
- ☐ 2 - Once a month
- ☐ 3 - Several times each month
- ☐ 4 - Several times a week
- ☐ 5 - At least daily

M0620: During the assessment, none of these behaviors is demonstrated, so Response 0 is marked.

COMMENTS: _____



ADDITIONAL OASIS ITEMS TO ASSESS DURING VIGNETTE 2

In addition to the noted items for which data could be collected during the vignette, the clinician can begin assessing other items as well. During a home health visit, a clinician gathers information that subsequently is analyzed and organized to answer other OASIS items (e.g., M0270 - Rehabilitative Prognosis). While viewing the scenario featuring Mrs. Bean's situation, you could begin to evaluate several other OASIS items:

M0175 - Inpatient Facilities
M0200 - Medical or Treatment Regimen Change Within Past 14 Days
M0260 - Overall Prognosis
M0270 - Rehabilitative Prognosis
M0280 - Life Expectancy
M0300 - Current Residence
M0340 - Patient Lives With
M0350 - Assisting Person(s) Other than Home Care Agency Staff
M0360 - Primary Caregiver
M0370 - How Often does the patient receive assistance from the primary caregiver
M0400 - Hearing and Ability to Understand Spoken Language
M0410 - Speech and Oral (Verbal) Expression of Language

Are there other items for which partial data are available?